

11335 CERTIFICATE OF DEATH

11289

Reg. Dist. No.

147

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unionville				c. LENGTH OF STAY IN 1b 10 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. Mt. Airy				d. STREET ADDRESS R.D. Mt. Airy			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BERTHA Middle B. Last ALBAUGH				4. DATE OF DEATH Month November Day 3 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-1873		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward Lindsay				14. MOTHER'S MAIDEN NAME Mary Naill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT C. Holly Albaugh,		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 5 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 1955, to Nov. , 1956, that I last saw the deceased alive on June , 1956, and that death occurred at 7 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W.B. Culwell M.D. Mt. Airy, Md 11/3/56 PHYSICIAN'S NAME (Type) W.B. Culwell							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-5-1956		22c. NAME OF CEMETERY OR CREMATORY Linganore		22d. LOCATION (City, town, or county) (State) Frederick Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Maryland		24a. RECEIVED BY REGISTRAR NOV 5 1956	
				24b. REGISTRAR'S SIGNATURE Clarice Runkley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED J. M. WELLS		AGE 65		SEX Male		RACE White		DATE OF DEATH 11-1-50		PLACE OF DEATH Home	
RESIDENCE 1111 N. W. Ave.		CITY Baltimore		COUNTY Baltimore		STATE Maryland		ZIP CODE 21205		MANNER OF DEATH Natural	
OCCUPATION Retired		EDUCATION High School		RELIGION Methodist		MARITAL STATUS Married		DATE OF MARRIAGE 1-1-23		NAME OF SPOUSE J. M. Wells	
CAUSE OF DEATH Heart Disease		IMMEDIATE CAUSE Myocardial Infarction		INTERMEDIATE CAUSE Coronary Artery Disease		FUNDAMENTAL CAUSE Atherosclerosis		MORBIDITY CODE 401.01		MORTALITY CODE 401.01	
DATE OF BIRTH 11-1-1885		PLACE OF BIRTH Baltimore		CITY OF BIRTH Baltimore		COUNTY OF BIRTH Baltimore		STATE OF BIRTH Maryland		ZIP CODE OF BIRTH 21205	
DATE OF DEATH 11-1-50		PLACE OF DEATH Home		CITY OF DEATH Baltimore		COUNTY OF DEATH Baltimore		STATE OF DEATH Maryland		ZIP CODE OF DEATH 21205	
OCCUPATION Retired		EDUCATION High School		RELIGION Methodist		MARITAL STATUS Married		DATE OF MARRIAGE 1-1-23		NAME OF SPOUSE J. M. Wells	
CAUSE OF DEATH Heart Disease		IMMEDIATE CAUSE Myocardial Infarction		INTERMEDIATE CAUSE Coronary Artery Disease		FUNDAMENTAL CAUSE Atherosclerosis		MORBIDITY CODE 401.01		MORTALITY CODE 401.01	

BUREAU V. 8

NOV 5 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11300 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11300

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Ohio b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 3 Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. STREET ADDRESS Eagle Rd. R.F.D.2	
3. NAME OF DECEASED (Type or print) First Charles Middle R / Last ieley Armington		4. DATE OF DEATH Month Nov. Day 9 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1937
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months 9 Days 19	IF UNDER 24 HRS. Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Cornell Univ.	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Raymond Q. Armington		14. MOTHER'S MAIDEN NAME Elizabeth Cole Rieley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Drivers licence		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portion of bone of skull was destroyed DUE TO thruu dura into brain tissue Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 hours (c) 3 hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 816X			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident. His car was struck by trailer truck	
20c. TIME OF INJURY Month, Day, Year 8-15 Hour II/9/56	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40	20f. (City or town) (County) (State) Route 40 Frederick Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> II/10/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 12, 1956	22c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery	22d. LOCATION (City, town, or county) (State) Cleveland Ohio
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 12 Nov 1956	
		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heek	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

11301

CERTIFICATE OF DEATH

11291

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
c. LENGTH OF STAY IN 1b 40 yrs.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 5 East 15th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Rollins Middle John Last Atkinson				4. DATE OF DEATH Month Nov. Day 27 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 1-1903	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min. 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Work		11. BIRTHPLACE (State or foreign country) Pennsylvania	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Work		10b. KIND OF BUSINESS OR INDUSTRY Sports Editor		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Justus B. Atkinson				14. MOTHER'S MAIDEN NAME Mary Elizabeth Rhinehart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-7854		17. INFORMANT Address Mrs. Rollins J. Atkinson 5 E. 15th St. Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 hrs 6 mos plus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 17 , 19 56 , to Nov 27 , 19 56 , that I last saw the deceased alive on Nov 27 , 19 56 , and that death occurred at 2:07 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE S R Schoolman M.D.				ADDRESS (Street, city or town, state) Professional Bldg. DATE SIGNED 11/28/56			
PHYSICIAN'S NAME (Type) Dr. L.R. Schoolman				Frederick- Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-30-1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick- Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son ADDRESS Frederick- Maryland				24a. REC'D BY REGISTRAR DATE 28 Nov. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
1956-10-29		Bureau V. S.		Bureau V. S.	
AGE		SEX		RACE	
10 years		Male		White	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
1946-10-19		Bureau V. S.		Bureau V. S.	
MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE COUNTRY	
1956-10-29		Bureau V. S.		Bureau V. S.	
OCCUPATION		EDUCATION		RELIGION	
Bureau V. S.		Bureau V. S.		Bureau V. S.	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
Bureau V. S.		Bureau V. S.		Bureau V. S.	
SIGNS AND SYMPTOMS		LABORATORY EXAMINATIONS		HISTORICAL INFORMATION	
Bureau V. S.		Bureau V. S.		Bureau V. S.	
POST-MORTEM EXAMINATION		TOXICOLOGICAL EXAMINATIONS		ANTHROPOLOGICAL EXAMINATIONS	
Bureau V. S.		Bureau V. S.		Bureau V. S.	
FAMILY HISTORY		SOCIAL HISTORY		LEGAL HISTORY	
Bureau V. S.		Bureau V. S.		Bureau V. S.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS	
Bureau V. S.		Bureau V. S.		Bureau V. S.	

RECEIVED

NOV 29 1956

BUREAU V. S.

11336

CERTIFICATE OF DEATH

11292

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg,				c. LENGTH OF STAY IN 1b 16 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#3				d. STREET ADDRESS R.D.#3			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Carrie R. Baker				4. DATE OF DEATH Month November Day 23 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1894		9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pa. Liberty Twp. Adams Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Baker				14. MOTHER'S MAIDEN NAME Julia Topper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-03-0831		17. INFORMANT Jacob E. Baker		Address Emmitsburg, R.D.#3 Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444x Uraemia DUE TO (b) cardio-renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260x DUE TO (c) Hypertensive cardio renal disease several years						INTERVAL BETWEEN ONSET AND DEATH 1 week 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 40 , 19 40 , to Nov 23 , 19 56 , that I last saw the deceased alive on Nov 22 , 19 56 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. R. Cade				ADDRESS (Street, city or town, state) Emmitsburg Md			
PHYSICIAN'S NAME (Type) S. L. Allison				DATE SIGNED 11-25-56			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		11/27/1956		St. Joseph's Catholic		Emmitsburg, Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison				ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR NOV 28 1956	
				24b. REGISTRAR'S SIGNATURE H. T. Hedrick			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan. 15, 1924		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan. 20, 1966		10:00 AM		Home		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Color		Religion		Education		Previous Illnesses		Alcohol Consumption		Tobacco Use		Hypertension		Diabetes		Other Conditions		Remarks	
Teacher		Married		White		Catholic		High School		None		Occasional		Daily		Yes		No		No		None	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Toxicologist		Signature of Forensic Pathologist		Signature of Forensic Toxicologist		Signature of Forensic Anthropologist		Signature of Forensic Archaeologist	
Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature	

BUREAU A: M

NOV 28 1966

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11337

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11293

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>IGAMSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>NEW MARKET</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Riggs Hospital Igamsville</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Maurice W. Baker</u>		4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>10</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 16 1876</u> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME BUILDING</u>	9. AGE last birthday <u>79</u> yrs.
13. FATHER'S NAME <u>WILLIAM T. BAKER</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>CATHERINE POOLE</u>	
16. SOCIAL SECURITY No. <u>217-28-5545</u>		17. INFORMANT AND ADDRESS <u>MRS ETHEL WHITEHILL FREDERICK MD</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4200 Immediate cause (a) Arteriosclerotic Heart Disease 1 year

Antecedent cause(s) (b) _____

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Cerebral Arteriosclerosis</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from AUG 5, 1954 to Nov 10, 1956, that I last saw the deceased alive on Nov 10, 1956 and that death occurred at 4:30 p.m., from the causes and on the date stated above.

SIGNATURE Joseph Lewis M.D. Igamsville Md ADDRESS Nov 10 56 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>Nov 13-56</u>	NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVET CEMETERY</u>	LOCATION (City, town, or county) <u>FREDERICK MD</u>	(State)
DATE REC'D BY LOCAL REG. <u>Nov 12-56</u>	REGISTRAR'S SIGNATURE <u>Lucy K. Falconer</u>	24. FUNERAL DIRECTOR <u>W E Falconer</u>	ADDRESS <u>New Market Md</u>	

RECEIVED

NOV 20 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11302 CERTIFICATE OF DEATH

11294
31

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 12 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BESSIE Middle VIRGINIA Last BRANDENBURG				4. DATE OF DEATH Month November 12, Day 19 Year 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Sept 1880	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Stockman				14. MOTHER'S MAIDEN NAME Ellen Harne			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT William L. Brandenburg Address (Same as Item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic bronchiectasis + bronchitis DUE TO (c) Arteriosclerotic cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 2 days 2 yrs 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April , 19 55 , to Nov 12 , 19 56 , that I last saw the deceased alive on Nov 11 , 19 56 , and that death occurred at 6:05A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Rex R. Martin				ADDRESS (Street, city or town, state) DATE SIGNED 35 E. Church St., Frederick, Md. 11/12/56			
PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 15 Nov 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 13 Nov 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

RECEIVED

NOV 15 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11303 CERTIFICATE OF DEATH

11295

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 hour	
f. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Graceham	
3. NAME OF DECEASED (Type or print) First William Middle Elmer Last Buhrman		4. DATE OF DEATH Month Nov Day 9 Year 1956	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1888
9. AGE (In years, last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Grocery		10b. KIND OF BUSINESS OR INDUSTRY Own Store	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alonza H. Buhrman		14. MOTHER'S MAIDEN NAME Emma K. Creeger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-5566	
17. INFORMANT Catherine M. Buhrman		Address Graceham, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vagmonhase DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1 day 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 9, 1956 , to Nov 9, 1956 , that I last saw the deceased alive on Nov 9, 1956 , and that death occurred at 6:20 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Frederick, Md. DATE SIGNED 11/9/56	
ACTUAL SIGNATURE A. A. Pearre M.D.		PHYSICIAN'S NAME (Type) Dr. A.A. Pearre	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-56	
22c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery		22d. LOCATION (City, town, or county) (State) Woodsboro Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond Creeger		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR Elizabeth L. Heck		24b. REGISTRAR'S SIGNATURE Elizabeth L. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 15 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11304

CERTIFICATE OF DEATH

11296

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS Doubs			
3. NAME OF DECEASED (Type or print) First VIRGINIA Middle MARIE Last FRY CASTLE				4. DATE OF DEATH Month November Day 20 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1913	9. AGE (In years last birthday) yrs. 43	IF UNDER 1 YEAR Months 1 Days 19 Hours 56 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elijah D. Fry				14. MOTHER'S MAIDEN NAME Lovie Umbaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Russell S. Castle, Doubs, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of the large intestine 153x DUE TO with metastases to the liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition, severe INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/1 , 19 56 , to 11/20 , 19 56 , that I last saw the deceased alive on 11/20 , 19 56 , and that death occurred at 11:50P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry V Chase M.D.				ADDRESS (Street, city or town, state) 44 E. Church St Frederick Md			
PHYSICIAN'S NAME (Type) Henry V. Chase				DATE SIGNED 11/21/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE HEREOF Nov. 24, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 24 Nov 1956		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

SERIES

BUREAU V. S.

1956 23/10

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11338 CERTIFICATE OF DEATH

11297

Reg. Dist. No. 13

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodboro</u>				c. LENGTH OF STAY IN 1b <u>35 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>Woodboro</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MORGAN EUGENE DAYHOFF</u>				4. DATE OF DEATH Month Day Year <u>Nov. 9 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11 1875</u>	9. AGE (In years lost birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James H. Dayhoff</u>				14. MOTHER'S MAIDEN NAME <u>Abbie Garver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-28-0854</u>		17. INFORMANT Address <u>Mrs Rebecca C. Dayhoff, Woodboro, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9 Nov</u> , 19 <u>56</u> to <u>9 Nov</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9 Nov</u> , 19 <u>56</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James F. Stoner, Jr. M.D. WALKERSVILLE, Md.</u> <u>10 NOV 1956</u>							
ACTUAL SIGNATURE <u>James F. Stoner, Jr.</u>				PHYSICIAN'S NAME (Type) <u>JAMES F. STONER, JR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove</u>		22d. LOCATION (City, town, or county) (State) <u>W. Unionville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Barton</u>				ADDRESS <u>Walkersville, md.</u>		24a. REC'D BY REGISTRAR DATE <u>14 Nov. 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Hech</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN lb <u>25 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Libertytown</u> d. STREET ADDRESS <u>MAIN ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Myrtie</u> First <u>Derilbiss</u> Middle <u>Derilbiss</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 6 - 1881</u> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>MILTON CARTER</u> 14. MOTHER'S MAIDEN NAME <u>ELIZABETH BAKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>JOHN M CARTER</u> Address <u>LIBERTYTOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Heart Disease & Congestive failure</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-23</u> , 19 <u>56</u> , to <u>11-18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-18</u> , 19 <u>56</u> , and that death occurred at <u>5:00 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>A. A. Pearre</u> M.D. <u>Frederick, Md</u> DATE SIGNED <u>11/18/56</u> PHYSICIAN'S NAME (Type) <u>A A PEARRE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>NOV 21 - 1956</u> 22c. NAME OF CEMETERY OR CREMATORY <u>LINGANORE</u> 22d. LOCATION (City, town, or county) (State) <u>UNIONVILLE MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartley & Sons Libertytown, Md</u> ADDRESS <u>Libertytown, Md</u> 24a. REC'D BY REGISTRAR DATE <u>23 Nov 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>			

VS A15 (4)
ISM 9/55

BUREAU V. S.

NOV 26 1956

RECEIVED

11306
CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u>		d. STREET ADDRESS <u>312 Kline Post Alley</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle Last		4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 3, 1956</u>
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Helms</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Leatha Diggs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>mother</u>		Address <u>312 Kline Post Alley</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Premature Separation Placenta.</u> (30 wks) <u>Premature labor.</u> (c) <u>(30 wks) Premature labor.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs 14 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11/30</u> , 19 <u>56</u> , to <u>11/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/30</u> , 19 <u>56</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry W Gray</u>		ADDRESS (Street, city or town, state) <u>355 Church St, Frederick, Md</u>	
PHYSICIAN'S NAME (Type) <u>HARRY W GRAY</u>		DATE SIGNED <u>11/30/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>30 Nov 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>30 Nov 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Elizabeth S Heck</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2069161XV0

CERTIFICATE OF DEATH

THE CIVIL SERVICE

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARITAL STATUS		OCCUPATION		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYMAN		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER		SIGNATURE OF JURY	

BUREAU V. 3

DEC 4 1956

RECEIVED

11339 CERTIFICATE OF DEATH

11300
Reg. Dist. No. 138

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Market				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Market			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First JOHN Middle HENRY Last DORSEY				4. DATE OF DEATH Month 11 Day 15 Year 1956			
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/1889	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DECORATOR		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) BARTHOLOWS, MD		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME JOHN HENRY DORSEY				14. MOTHER'S MAIDEN NAME EVA PHILLIPS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W.#1 219-20-0797		17. INFORMANT BOX#382 Rt/#2 MRS. AUGUSTA HAWKINS-FURNACE BR. RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. 260x (b) Arterio sclerosis DUE TO (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 15, 1956 , to Nov 15, 1956 , that I last saw the deceased alive on Nov 15, 1956 , and that death occurred at 1:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED R. d. Michels M.D. PS. Essential information as to diagnosis was obtained from Dr. B. O. Thomas Sr. Frederick							
22a. FUNERAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		11/19/56		Balds Hill		Balds Hill	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. Horpa				24a. REC'D BY REGISTRAR Mr. 19, 1956		24b. REGISTRAR'S SIGNATURE Lucius L. Falconer	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 20 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18	
CERTIFICATE OF DEATH	
NAME OF DECEASED JOHN HENRY DORSEY	
DATE OF DEATH 11/17/56	
PLACE OF DEATH BALTIMORE, MARYLAND	
AGE 68	
SEX M	
RACE W	
EDUCATION H	
OCCUPATION LABORER	
MARRIED X	
SPOUSE'S NAME MARY DORSEY	
DECEASED'S BIRTH 11/17/56	
DECEASED'S DEATH 11/17/56	
DECEASED'S CAUSE HEART DISEASE	
DECEASED'S PLACE BALTIMORE, MARYLAND	
DECEASED'S RESIDENCE BALTIMORE, MARYLAND	
DECEASED'S RELATIONSHIP HUSBAND	
DECEASED'S SIGNATURE JOHN HENRY DORSEY	
DECEASED'S ADDRESS BALTIMORE, MARYLAND	
DECEASED'S PHONE BALTIMORE, MARYLAND	
DECEASED'S MAILING ADDRESS BALTIMORE, MARYLAND	
DECEASED'S SOCIAL SECURITY NUMBER BALTIMORE, MARYLAND	
DECEASED'S MARITAL STATUS MARRIED	
DECEASED'S OCCUPATION LABORER	
DECEASED'S EDUCATION H	
DECEASED'S RACE W	
DECEASED'S SEX M	
DECEASED'S AGE 68	
DECEASED'S DATE OF DEATH 11/17/56	
DECEASED'S PLACE OF DEATH BALTIMORE, MARYLAND	
DECEASED'S NAME JOHN HENRY DORSEY	

11340 CERTIFICATE OF DEATH

11301

Reg. Dist. No. 138

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Riggs Hospital</u>		d. STREET ADDRESS <u>309 Rockwell Terrace</u>	
3. NAME OF DECEASED (Type or print) <u>EVALINE</u> First <u>Duve'</u> Middle <u>Duve'</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>17</u> Day <u>1956</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George E. Tulloch</u>		14. MOTHER'S MAIDEN NAME <u>M. LUTITIA Flanegin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DR. J. D. DUVE</u> Address <u>309 Rockwell Terrace</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 MDS</u> <u>5 YRS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 4, 1953</u> to <u>Nov 17, 1956</u> that I last saw the deceased alive on <u>Nov 17, 1956</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Frederick, Md.</u> DATE SIGNED <u>Nov 17, 1956</u>			
ACTUAL SIGNATURE <u>Joseph Lerner</u> M.D.		PHYSICIAN'S NAME (Type) <u>Joseph Lerner M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-20-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Allegheny Co. Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>NR. PITTSBURGH - PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son</u> ADDRESS <u>Frederick - Md.</u>		24a. REC'D BY REGISTRAR <u>20 Nov 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Lucian Kalcman</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John E. Thompson</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1910</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>1935</i></p>	
<p>9. NAME OF SPOUSE <i>Elizabeth Thompson</i></p>		<p>10. DATE OF DEATH <i>1956</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>		<p>16. OFFICIAL USE <i>[Blank]</i></p>	

BUREAU V. 2

1956

RECEIVED

11307 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN IB One week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital				d. STREET ADDRESS Rocky Ridge			
3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Eckernode				4. DATE OF DEATH Month Nov. Day 13. Year 19 56			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 18, 1977	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79		IF UNDER 24 HRS. Days 79 Hours 79 Min. 79		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham C. Myers				14. MOTHER'S MAIDEN NAME Sarah A. Hoover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Ernest Ridge Thurmont, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Scirrhus carcinoma Rt. BREAST DUE TO 170x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260x (b) Carcinomatosis, generalized DUE TO Diabetes mellitus (c) Fracture Pathological Rt. Hip						INTERVAL BETWEEN ONSET AND DEATH 6 months 3 " ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture Pathological Rt. Hip						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 11-7 , 19 56 , to 11-13 , 19 56 , that I last saw the deceased alive on 11-13 , 19 56 , and that death occurred at 4:15 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Thurmont E. Stone		M.D. 4 W 3 rd St Frederick 11-19/56		DATE SIGNED 11-19/56			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-16-56		22c. NAME OF CEMETERY OR CREMATORY Church of Brethern Cen.		22d. LOCATION (City, town, or county) (State) Rocky Ridge Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond B. Creager		ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE 16 Nov. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 19 1956

RECEIVED

11303

11308 CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 2 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 460 West Patrick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Amos Fisher		4. DATE OF DEATH Month Nov. Day 13 Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2-1895
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Janitor		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Montgomery Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Thomas Fisher		14. MOTHER'S MAIDEN NAME Maggie Rhin Rhion	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-2253	
17. INFORMANT Grace Fisher		Address 113 Ice Street Frederick-Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1955 , to Nov 13, 1956 , that I last saw the deceased alive on Nov 12, 1956 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 35 E. Church Frederick Md DATE SIGNED 11-13-56			
ACTUAL SIGNATURE Rex R. Martin		M.D. 35 E. Church Street Frederick-Md.	
PHYSICIAN'S NAME (Type) Rex R. Martin		35 East Church Street Frederick-Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 16-56	
22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III Fred. Md.		24a. REC'D BY REGISTRAR DATE 14 Nov 1956	
24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck			

VS A15 (2)
15M 9/24

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Age: <u>56</u></p>	
<p>5. Place of birth: <u>New York City</u></p>		<p>6. Usual residence: <u>123 Main St, Baltimore, Md</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Date of death: <u>Nov 15, 1956</u></p>	
<p>9. Time of death: <u>10:30 AM</u></p>		<p>10. Place of death: <u>Home</u></p>	
<p>11. Signature of physician: <u>Dr. J. K. Smith</u></p>		<p>12. Signature of registrar: <u>John Doe</u></p>	
<p>13. Signature of informant: <u>John Doe</u></p>		<p>14. Address of informant: <u>123 Main St, Baltimore, Md</u></p>	
<p>15. Date of filing: <u>Nov 16, 1956</u></p>		<p>16. File number: <u>123456</u></p>	

BUREAU V. S.

NOV 16 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11341

CERTIFICATE OF DEATH

11304

Reg. Dist. No. 138

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia				c. LENGTH OF STAY IN lb 50 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First VIRGIE Middle REBECCA Last GANLEY				4. DATE OF DEATH Month November 24, Day 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 2, 1885	
9. AGE (In years last birthday) 71 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John Knott			
14. MOTHER'S MAIDEN NAME Sara Ellen Meazell				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Address Mr. J. Hickman Ganley, Monrovia, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic heart disease (c) Diabetes mellitus							INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 years app. 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept. 24, 1956 , to Nov. 24, 1956 , that I lost saw the deceased olive on Nov. 24, 1956 , and that death occurred at 12:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph L. Michels				ADDRESS (Street, city or town, state) New Market, Maryland			
DATE SIGNED 11/25/1956				PHYSICIAN'S NAME (Type) Dr. Ralph L. Michels			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 28, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
22d. LOCATION (City, town, or county) (State) Frederick, Maryland				23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland			
24a. REC'D BY REGISTRAR DATE Nov-26-56				24b. REGISTRAR'S SIGNATURE Lucian K. Fakoner			

CERTIFICATE OF DEATH

NAME OF DECEASED John Joseph		SEX Male	
DATE OF BIRTH 10/10/1912		PLACE OF BIRTH Baltimore, Maryland	
OCCUPATION Clerk		CAUSE OF DEATH Myocardial Infarction	
DATE OF DEATH 11/15/1966		PLACE OF DEATH Baltimore, Maryland	
TIME OF DEATH 10:15 AM		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF NEXT OF KIN [Signature]		SIGNATURE OF CORONER [Signature]	
SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF CLERK [Signature]	

RECEIVED
 NOV 27 1966
 BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11342

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11305

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) ✓ a. STATE Ill. b. COUNTY McHenry 57x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 40		c. LENGTH OF STAY IN 1b 335 Hilkert Center, Crystal Lake	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 335 Hilkert Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pvt. George Middle R Last Gellert		4. DATE OF DEATH Month Nov. Day 9 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1933
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months 23 Days 23	IF UNDER 24 HRS. Hours 23 Min. 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Donald N. Gellert	
14. MOTHER'S MAIDEN NAME Unknown (deceased)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. Yes		17. INFORMANT Drivers licence Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed skull DUE TO Fracture of neck Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 816x (c) Minutes		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident. Car he was in was struck by trailer tractor	
20c. TIME OF INJURY Month, Day, Year 8-15 p. m. 11/9/56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) (County) (State) Frederick Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/10/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Nov. 12-1956	
22c. NAME OF CEMETERY OR CREMATORY Removal		22d. LOCATION (City, town, or county) (State) Chicago Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		ADDRESS Frederick- Maryland	
24a. REC'D BY REGISTRAR 12 Nov 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		35		M		W		1956		New York City	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
1234 Main St., New York City		Police Officer		Heart Disease		Natural		Catholics		1956	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE OF EXAMINER		OFFICE OF EXAMINER	
1956		10:00 AM		New York City		J. J. Jones		Medical Examiner		New York City	
DATE OF REPORT		TIME OF REPORT		PLACE OF REPORT		SIGNATURE OF REPORTER		TITLE OF REPORTER		OFFICE OF REPORTER	
1956		10:00 AM		New York City		J. J. Jones		Medical Examiner		New York City	

BUREAU V. 8

NOV 15 1956

RECEIVED

11343

CERTIFICATE OF DEATH

Reg. Dist. No.

81

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE RURAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE RURAL			
c. LENGTH OF STAY IN 1b YEARS				d. STREET ADDRESS JOHNSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION JOHNSVILLE				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ABRAHAM WEBSTER GRABILL				4. DATE OF DEATH NOV 10 1956			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/3/1860	
9. AGE (In years last birthday) 96 yrs.		10. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUAL GRABILL				14. MOTHER'S MAIDEN NAME ABBEY REPP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT RENO GRABILL Address RURAL UNION BRIDGE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Samual Kehlig Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 Week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Nov 1 , 19 56 to Nov 10 , 19 56 that I last saw the deceased alive on Nov 9 , 19 56 , and that death occurred at 6 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. H. MESSLER				ADDRESS (Street, city or town, state) Union Bridge Md. DATE SIGNED 11/10/56			
PHYSICIAN'S NAME (Type) J. H. MESSLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov 13-1956		22c. NAME OF CEMETERY OR CREMATORY BEAVER DAM		22d. LOCATION (City, town, or county) (State) FREDERICK Co MD	
23. FUNERAL DIRECTOR'S SIGNATURE D. Hartzler ADDRESS Union Bridge Md.				24a. REC'D BY REGISTRAR DATE Nov 12 1956		24b. REGISTRAR'S SIGNATURE Lillie L. Repp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1-10

<p>1. Name of deceased (Print name and last name) JAMES EARL RAY</p>		<p>2. Sex Male</p>	
<p>3. Date of birth (Month, day, year) May 19, 1928</p>		<p>4. Place of birth (City, State, Country) Jackson, Mississippi, U.S.A.</p>	
<p>5. Date of death (Month, day, year) May 14, 1968</p>		<p>6. Place of death (City, State, Country) Jackson, Mississippi, U.S.A.</p>	
<p>7. Cause of death (List all causes, beginning with immediate cause) 1. Gunshot wound of the chest 2. Hemorrhage 3. Shock</p>		<p>8. Manner of death (Check one) <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined</p>	
<p>9. Signature of physician (Print name and last name) JAMES EARL RAY</p>		<p>10. Signature of registrar (Print name and last name) JAMES EARL RAY</p>	
<p>11. Signature of medical examiner (Print name and last name) JAMES EARL RAY</p>		<p>12. Signature of coroner (Print name and last name) JAMES EARL RAY</p>	

BUREAU V. S.

NOV 14 1966

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11309 CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Louisville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital				d. STREET ADDRESS R.F.D. Finksburg			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LAURA Middle B. Last GRIMES				4. DATE OF DEATH Month 11 Day 26 Year 1956			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 -11 - 1869	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas W. Simmons				14. MOTHER'S MAIDEN NAME Annie Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----		17. INFORMANT Address W.N. Grimes, 601 W. Patrick St. Fred. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/25 , 19 56 , to 11/26 , 19 56 , that I last saw the deceased alive on 11/25 , 19 56 , and that death occurred at 3:10 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James B. Thomas M.D.				ADDRESS (Street, city or town, state) Frederick, Maryland		DATE SIGNED 11/26/56	
PHYSICIAN'S NAME (Type) JAMES B. THOMAS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-28-1956		22c. NAME OF CEMETERY OR CREMATORIUM Providence		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. M. Waltz, Winfield, Maryland				24a. REC'D BY REGISTRAR DATE 28 1956		24b. REGISTRAR'S SIGNATURE Ely. Decker	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

244

BUREAU V. S.

NOV 28 1956

RECEIVED

11344

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE RURAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION JOHNSVILLE				d. STREET ADDRESS JOHNSVILLE			
3. NAME OF DECEASED (Type or print) First Middle Last EFFIE SMITH GROSSNICKLE				4. DATE OF DEATH Month Day Year NOVEMBER 5 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 14-1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JACOB SMITH				14. MOTHER'S MAIDEN NAME MARY GHEO			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 214-34-3802			
17. INFORMANT VERNON GROSSNICKLE				Address RURAL UNION BRIDGE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOIS 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 10 YEARS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHIAL PNEUMONIA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1 June 1950 to 5 Nov 1956 , that I last saw the deceased alive on 4 November 1956 , and that death occurred at 10:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5 NOV 1956							
ACTUAL SIGNATURE James E. Stoner, Jr. M.D.							
PHYSICIAN'S NAME (Type) JAMES E. STONER, JR.				WALKERSVILLE, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT 8-1956		22c. NAME OF CEMETERY OR CREMATORY BEAVER DAM		22d. LOCATION (City, town, or county) (State) FREDERICK CO MD	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hartley & Sons Union Bridge Md				24a. REC'D BY REGISTRAR Nov 8, 1956		24b. REGISTRAR'S SIGNATURE Leah L. Repps	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11310 CERTIFICATE OF DEATH

11309/31
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>			
c. LENGTH OF STAY IN 1b <u>10 days</u>				d. STREET ADDRESS <u>Hill Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hayes</u> First <u>Gue</u> Middle Last				4. DATE OF DEATH <u>Nov.</u> Month <u>27</u> Day <u>1956</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-2-1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O.R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horace Gue</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Moxley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-----</u>			
17. INFORMANT <u>Mrs. Alice Gue, Mt. Airy, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>6 yrs +</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/18</u> , 19 <u>56</u> , to <u>11/27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/27</u> , 19 <u>56</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>11/27/56</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				<u>Frederick Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE/THEREOF <u>11-30-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u> ADDRESS <u>Winfield, Maryland</u>				24a. REC'D BY REGISTRAR <u>NOV 29 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Ely S. Necko</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1910 CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE		OCCUPATION	
JAMES H. HARRIS		45		M		W		MARRIED		LABORER	
PLACE OF BIRTH		DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD.		JAN 15 1865		JAN 15 1910		10:30 AM		HEART DISEASE		NATURAL	
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
BALTIMORE, MD.		JAN 15 1910		10:30 AM		HEART DISEASE		NATURAL		J. H. HARRIS	
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
BALTIMORE, MD.		JAN 15 1910		10:30 AM		HEART DISEASE		NATURAL		J. H. HARRIS	

RECEIVED

NOV 29 1956

BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11345

CERTIFICATE OF DEATH

11310

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.F.D.#2				c. LENGTH OF STAY IN 1b Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hope Hill				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED ALSO KNOWN AS JAMES FRANKLIN HACKEY				4. DATE OF DEATH Month November Day 21 Year 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1880		9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Hollins Hackey				14. MOTHER'S MAIDEN NAME Sarah Elizabeth Hackey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Walter Diggs			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio vascular 422.1 DUE TO Arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) gangrene of big toe at foot (c)				INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 10, 1956 to Nov 21, 1956 , that I last saw the deceased alive on Nov 20, 1956 , and that death occurred at 9:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE B. O. Thomas M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 228 N. Market St., Frederick, Md. 11/26/56			
PHYSICIAN'S NAME (Type) B. O. Thomas, Sr.				Professional Bldg, Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/26/56		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Centerville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Md.				24a. REC'D BY REGISTRAR DATE 26 Nov 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Herb	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HILL		Male		30		1926	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1000 E. 10th St. Baltimore, Md.		Carpenter		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TIME OF DEATH	
November 15, 1956		Home		10:00 AM		11:00 AM	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF ATTENDING PHYSICIAN	
J. H. Hill		None		None		J. H. Hill	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF ATTENDING PHYSICIAN	
J. H. Hill		None		None		J. H. Hill	

BUREAU V. S.

NOV 17 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11311 CERTIFICATE OF DEATH

Reg. Dist. No. 11

11311

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 7 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 190 West All Saints Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle GERTRUDE Last HALL		4. DATE OF DEATH Month November Day 14 Year 19 56	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1865
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Murdock	
14. MOTHER'S MAIDEN NAME Mary Henrietta Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary C. Dorsey, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 11/10 to 11/14 , 19 56 , that I last saw the deceased alive on 11/10 , 19 56 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James B. Thomas		M.D. Professional Bldg., Frederick, Md DATE SIGNED 11/15/56	
PHYSICIAN'S NAME (Type) Dr. James B. Thomas		Same as above	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 17, 1956	22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 16 Nov. 1956	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

CERTIFICATE OF DEATH

Name of Deceased		John W. WOODS	
Sex		Male	
Age		72	
Date of Birth		January 27, 1885	
Place of Birth		Maryland	
Usual Residence		120 West 11th Street, Baltimore, Md.	
Cause of Death		Heart Disease	
Date of Death		November 19, 1956	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

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NOV 19 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11346 CERTIFICATE OF DEATH

Reg. Dist. No.

11312

139

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillsville Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillsville Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Jesse Middle Martin Last Harbaugh		4. DATE OF DEATH Month Nov. Day 6 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-17-1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Grit Mill	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Harbaugh		14. MOTHER'S MAIDEN NAME Mary Harbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-16-1765	
17. INFORMANT Mrs. Nelda Harbaugh		Address Sabillsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 5 Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April , 19 56 , to Nov 6 , 19 56 , that I last saw the deceased alive on Nov 6 , 19 56 , and that death occurred at 5:42 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert A. Kiefer		ADDRESS (Street, city or town, state) DATE SIGNED Blue Ridge Cemetery, Thurmont, Md. 6 Nov 56	
PHYSICIAN'S NAME (Type) Dr. Robert A. Kiefer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-9-56	22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Thurmont, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		24a. REC'D BY REGISTRAR NOV 9 1956	
ADDRESS Thurmont, Md.		24b. REGISTRAR'S SIGNATURE Sam B. Lyons	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRISON		AGE 45 YRS.		SEX MALE		RACE WHITE		DATE OF DEATH NOV 8 1956	
PLACE OF DEATH BALTIMORE, MD.		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD.		ZIP CODE 21201	
OCCUPATION LABORER		EDUCATION HIGH SCHOOL		MARRIAGE MARRIED		RELIGION METHODIST		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION		UNDERLYING CAUSE ARTERIOSCLEROSIS		MORBIDITY NO	
DATE OF BIRTH OCT 15 1911		PLACE OF BIRTH BALTIMORE, MD.		PARENTS JAMES H. HARRISON & MARY E. HARRISON		SIBLINGS JOHN H. HARRISON, MARY E. HARRISON		MILITARY SERVICE NO	
DATE OF DEATH NOV 8 1956		PLACE OF DEATH BALTIMORE, MD.		CITY BALTIMORE		COUNTY BALTIMORE		STATE MD.	
OCCUPATION LABORER		EDUCATION HIGH SCHOOL		MARRIAGE MARRIED		RELIGION METHODIST		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION		UNDERLYING CAUSE ARTERIOSCLEROSIS		MORBIDITY NO	
DATE OF BIRTH OCT 15 1911		PLACE OF BIRTH BALTIMORE, MD.		PARENTS JAMES H. HARRISON & MARY E. HARRISON		SIBLINGS JOHN H. HARRISON, MARY E. HARRISON		MILITARY SERVICE NO	

BUREAU V. S.

NOV 9 1956

RECEIVED

1

11312

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11313

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <u>FREDERICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL</u>		d. STREET ADDRESS <u>127 WEST PATRICK ST</u>	
3. NAME OF DECEASED (Type or print) <u>WANDA DARLENE HARLEY</u>		4. DATE OF DEATH <u>NOVEMBER 19 56</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 14</u>
9. AGE (In years last birthday) <u>0</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEW BORN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHARLES FRANKLIN HARLEY JR.</u>		14. MOTHER'S MAIDEN NAME <u>ROSELLA STEWENS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal atelectasis</u> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/14</u> , 19 <u>56</u> , to <u>11/14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>56</u> , and that death occurred at <u>8:13 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James B. Thomas</u> M.D.		ADDRESS (Street, city or town, state) <u>Frederick, Md.</u> DATE SIGNED <u>11/16/56</u>	
PHYSICIAN'S NAME (Type) <u>JAMES B. THOMAS</u>		<u>Frederick Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 16, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Int Olivet Cem</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DATE 16 Nov. 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2069201XV4

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES B. THOMAS		M		45		1911		BALTIMORE, MD.	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE	
LABORER		HIGH SCHOOL		MARRIED		METHODIST		WHITE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
HEART DISEASE		NATURAL		HOME		OCT 15, 1956		10:30 AM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF REGISTRAR	
J. R. THOMAS		J. R. THOMAS		J. R. THOMAS		J. R. THOMAS		J. R. THOMAS	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
OCT 15, 1956		HOME		OCT 15, 1956		HOME		OCT 15, 1956	

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NOV 19 1956

RECEIVED

M. R. Richardson & Son, Frederick, Md.

JAMES B. THOMAS

Frederick, Md.

CERTIFICATE OF DEATH

Reg. Dist. No.

11314

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Smithsburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Smithsburg			
c. LENGTH OF STAY IN 1b 76 yrs.				d. STREET ADDRESS Route # 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES ELLSWORTH HESSONG				4. DATE OF DEATH Month November Day 6 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1870		9. AGE (In years last birthday) yrs. 86	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own General Farm		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John Hessong			
14. MOTHER'S MAIDEN NAME Matilda Kline				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. none				17. INFORMANT Mrs. Sadie Hessong, Smithsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 6 Mo. 5 Yrs.						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 11/4 , 19 54 , to 11/6 , 19 56 , that I last saw the deceased alive on 11/6 , 19 56 , and that death occurred at 12:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. Hess M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 11/7/56			
PHYSICIAN'S NAME (Type) Charles F. Hess M.D.				Smithsburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Marks Lutheran		22d. LOCATION (City, town, or county) (State) Wolfsville, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle				ADDRESS Myersville, Md.		24a. REC'D BY REGISTRAR DATE Nov 9, 1956	
24b. REGISTRAR'S SIGNATURE Paul F. Bittle							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11313
CERTIFICATE OF DEATH

11315

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 11 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montevue				d. STREET ADDRESS 31 East Sixth Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ALICE Middle SUSAN Last HOSSLER			4. DATE OF DEATH Month November Day 14 , Year 1956				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1882		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Resturant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marshall E. Waltz				14. MOTHER'S MAIDEN NAME Laura Harnas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-05-5952		17. INFORMANT Mr. Ransom W. Hossler, 31 East Sixth Street, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April 1, 1956 , to 11/14/56 , that I last saw the deceased alive on Nov. 10, 1956 , and that death occurred at 6:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg., Frederick, Md. DATE SIGNED 11/16/56							
ACTUAL SIGNATURE Bernard O. Thomas Jr. M.D.							
PHYSICIAN'S NAME (Type) Dr. B. O. Thomas Jr.				Same as above			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 17, 1956		22c. NAME OF CEMETERY OR CREMATORY Union Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 16 Nov. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hecker	

BUREAU V.

NOV 19 1956

RECEIVED

11314 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 26 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARE Middle KATHRYN Last KEPLER				4. DATE OF DEATH Month Nov. Day 22 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 July 1928	
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Walter David Feely				14. MOTHER'S MAIDEN NAME Miriam Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-24-5318		17. INFORMANT James H. Kepler (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma bronchogenic 162x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/22 , 19 56 , to 11/22 , 19 56 , that I last saw the deceased alive on 11/22 , 19 56 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE L. R. Schoolman M.D. 228 N. Washington St. Fred. Md. 11/22/56 PHYSICIAN'S NAME (Type) L. R. Schoolman, M. D.							
22a. BURIAL, CREMATION, or other (Specify) Burial		22b. DATE THEREOF 24 Nov 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 24 Nov. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. VENTER		M		45		1911		BALTIMORE		MD		USA			
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Salesman		High School		Married		Catholic		White		White		Brown		Blue	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
Nov 27 1956		Home		Natural Causes		Natural		Heart Disease		Chest Pain		Medicine		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF JUDGE	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
Nov 27 1956		Nov 27 1956		Nov 27 1956		Nov 27 1956		Nov 27 1956		Nov 27 1956		Nov 27 1956		Nov 27 1956	

BUREAU V. S.

NOV 27 1956

RECEIVED

11333

CERTIFICATE OF DEATH

Reg. Dist. No.

141

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 501 East Potomac				d. STREET ADDRESS 501 East Potomac			
3. NAME OF DECEASED (Type or print) First Sudie Middle Elizabeth Last Kidwell				4. DATE OF DEATH Month II Day 19 Year 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-II-1867	9. AGE (In years last birthday) yrs. 89	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Samuel Mann				14. MOTHER'S MAIDEN NAME Mary Bartlett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Address Mrs. Irene Chambers, Brunswick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Serum Sickness DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 wks.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 19, 1956 to Nov. 19, 1956 , that I last saw the deceased alive on Nov. 19, 1956 , and that death occurred at 9 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Md. DATE SIGNED 11-23-56							
ACTUAL SIGNATURE C.E. Pruitt M.D. Brunswick, Md.							
PHYSICIAN'S NAME (Type) C.E. Pruitt							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF II-23-56		22c. NAME OF CEMETERY OR CREMATORY Park Heights		22d. LOCATION (City, town, or county) (State) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. K. Teate				ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR NOV 26 1956	
				24b. REGISTRAR'S SIGNATURE Eugenia Burke			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARITAL STATUS		OCCUPATION	
JAMES EARL RAY		APRIL 14, 1928		MALE		WHITE		SINGLE		UNEMPLOYED	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENNESSEE		APRIL 4, 1968		4:30 PM		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE	
DISEASE OR INJURY		MEDICAL HISTORY		PREVIOUS ILLNESS		TREATMENT		HISTORICAL		LABORATORY	
HEART DISEASE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		DATE		DATE		DATE		DATE		DATE	
APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	

BUREAU V. R.

NOV 28 1966

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11315 CERTIFICATE OF DEATH

Reg. Dist. No. 131

11318

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 10 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 317 West South Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) First DAISY Middle MAY Last KOHLNBURG		4. DATE OF DEATH Month November 19, Day 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5 May 1873
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Margaret Park, Frederick, Maryland		318 E. Patrick St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery atherosclerosis with acute myocardial infarction 420.1 DUE TO cardiac infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO Serility (c) Serility INTERVAL BETWEEN ONSET AND DEATH sudden 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 1954, to Nov. 19 , 1956, that I last saw the deceased alive on Oct 20 , 1956, and that death occurred at 7 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 35 E. Church 7 Frederick Md. 11-19-56			
ACTUAL SIGNATURE Rex R. Martin		M.D. 35 E. Church 7 Frederick Md. 11-19-56	
PERSON'S NAME (Type) Rex R. Martin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Burial: 11-23-56	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, 4210 Belair RD., Balto. Md.		24a. REC'D BY REGISTRAR 20 Nov 1956	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Heub			

11316

CERTIFICATE OF DEATH

Reg. Dist. No.

11319

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 50 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 124 West Fourth Street				d. STREET ADDRESS 124 West Fourth Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JACOB Middle HARBAUGH Last MACKLEY				4. DATE OF DEATH Month November Day 3 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 May 1866 1866	
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk				10b. KIND OF BUSINESS OR INDUSTRY Wholesale Grocery		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Milton Mackley				14. MOTHER'S MAIDEN NAME Mary Little			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-10-4435		17. INFORMANT Mrs. Blanche Mackley, (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 min. 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1936 , to Mar 3 , 19 56 , that I last saw the deceased alive on Oct 3 , 19 56 , and that death occurred at 9 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7 N. Market St., Frederick, Md. DATE SIGNED 11/5/56 ACTUAL SIGNATURE H. F. Kline M.D. PHYSICIAN'S NAME (Type) H. F. Kline, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6 Nov 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 5 Nov 1956		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

CERTIFICATE OF DEATH

Name of Deceased Frederick		Sex Male		Age 20 years		Date of Birth 12 May 1906		Place of Birth Baltimore, Maryland		Cause of Death Heart Disease	
Residence 121 East Avenue Street		Occupation Student		Date of Death 12 May 1926		Place of Death Baltimore, Maryland		Physician Dr. J. H. Smith		Manner of Death Natural	
Signature of Physician Dr. J. H. Smith		Signature of Registrar John Doe		Signature of Deceased Frederick		Signature of Family John Doe		Signature of Friend John Doe		Signature of Neighbor John Doe	
Name of Deceased Frederick		Sex Male		Age 20 years		Date of Birth 12 May 1906		Place of Birth Baltimore, Maryland		Cause of Death Heart Disease	
Residence 121 East Avenue Street		Occupation Student		Date of Death 12 May 1926		Place of Death Baltimore, Maryland		Physician Dr. J. H. Smith		Manner of Death Natural	
Signature of Physician Dr. J. H. Smith		Signature of Registrar John Doe		Signature of Deceased Frederick		Signature of Family John Doe		Signature of Friend John Doe		Signature of Neighbor John Doe	

BUREAU W. E.

NOV 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11320

11317 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 610 Military Road				d. STREET ADDRESS 610 Military Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARTIN Middle LUTHER Last MAHONEY				4. DATE OF DEATH Month November Day 14 , Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 15, 1884	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Francis Mahoney				14. MOTHER'S MAIDEN NAME Amanda Ausherman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-10-2761A		17. INFORMANT Mrs. Grace R. Mahoney, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Stenosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) Arterio Sclerosis INTERVAL BETWEEN ONSET AND DEATH 2 yrs + 10 yrs + 10 yrs +							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <input type="checkbox"/> p. m. <input checked="" type="checkbox"/> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frederick,				20g. (County) Maryland		20h. (State) Maryland	
21. I certify that I attended the deceased from May , 1945, to Nov. 14 , 1956, that I last saw the deceased alive on Nov. 14 , 1956, and that death occurred at 6:45 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg., Frederick, Md DATE SIGNED 11/16/56 ACTUAL SIGNATURE B. O. Thomas M.D. Professional Bldg., Frederick, Md PHYSICIAN'S NAME (Type) Dr. B. O. Thomas Sr. Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 17, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
22d. LOCATION (City, town, or county) Frederick,				22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 16 Nov. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Physician's Signature		Registrar's Signature		Date of Registration		Place of Registration	
JAMES H. HARRIS		Male		45		1911		Maryland		Baltimore		Heart Disease		November 19, 1956		10:30 AM		Home		Natural		J. H. Harris		J. H. Harris		November 19, 1956		Baltimore	
Occupation		Marital Status		Color		Height		Weight		Education		Previous Illnesses		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Last Medical Examination		Last Medical Advice	
Teacher		Married		White		5' 8"		170		High School		None		November 15, 1956		November 15, 1956		November 15, 1956		November 15, 1956		November 15, 1956		November 15, 1956		November 15, 1956		November 15, 1956	
Cause of Death		Manner of Death		Physician's Signature		Registrar's Signature		Date of Registration		Place of Registration		Cause of Death		Manner of Death		Physician's Signature		Registrar's Signature		Date of Registration		Place of Registration		Cause of Death		Manner of Death		Physician's Signature	
Heart Disease		Natural		J. H. Harris		J. H. Harris		November 19, 1956		Baltimore		Heart Disease		Natural		J. H. Harris		J. H. Harris		November 19, 1956		Baltimore		Heart Disease		Natural		J. H. Harris	

BUREAU V. S.

NOV 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11318 CERTIFICATE OF DEATH

Reg. Dist. No. 13

11321

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOME FOR THE AGED		d. STREET ADDRESS 115 Record	
3. NAME OF DECEASED (Type or print) First ELIZA Middle DOWNEY Last MAYNARD		4. DATE OF DEATH Month NOVEMBER Day 21 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1867
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Widowed		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Liberty Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN DOWNEY		14. MOTHER'S MAIDEN NAME ELIZABETH DORSEY JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. MAUDE KEFAUVER		Address HOME FOR THE AGED.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Congestive Failure 420.0 DUE TO Arterio-sclerotic heart dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 month 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 1952 , 19____, to 21 Nov. , 19 56 , that I last saw the deceased alive on 20 Nov. , 19 56 , and that death occurred at 11 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles H Conelly Jr.		ADDRESS (Street, city or town, state) Professional Bldg Frederick, Md	
PHYSICIAN'S NAME (Type) DR. CHARLES CONELLY JR.		DATE SIGNED 11/21/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 23, 56	
22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		22d. LOCATION (City, town, or county) FREDERICK MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE DAILEY'S FUNERAL HOME		24a. REC'D BY REGISTRAR 23 Nov. 1956	
24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck			

1956 95-101

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11319

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 FilmG207 11-20-56 et

11322

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#1	
3. NAME OF DECEASED (Type or print) First HENRY Middle D. Last McMANN		4. DATE OF DEATH Month November Day 8, Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 1 June 1877 1887
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11b. KIND OF BUSINESS OR INDUSTRY Day Laborer	
11c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Howard M. Albaugh,		336 E. 3rd St., Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture base of Skull 812X DUE TO Fracture of pelvis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Ruptured bladder DUE TO Compound fracture of left leg (c)		INTERVAL BETWEEN ONSET AND DEATH 73 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by Automobile While Crossing Street	
20c. TIME OF INJURY Month, Day, Year 6:30 11/7, 19 56 Hour 11 p. m. 7		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Frederick-Frederick-Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		DATE SIGNED	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12 Nov 1956	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 12 Nov. 1956	
		24b. REGISTRAR'S SIGNATURE Elizabeth L. Hesch	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		10/15/55	
Place of Birth		Race		Occupation		Cause of Death	
New York		White		Teacher		Heart Disease	
Date of Birth		Marital Status		Education		Manner of Death	
10/15/20		Married		High School		Natural	
Place of Death		Residence		Hospital		Physician	
New York		123 Main St		St. John's		Dr. Smith	
Date of Death		Time of Death		Signature of Examiner		Signature of Physician	
10/15/55		10:00 AM		J. Doe		Dr. Smith	
Place of Death		Residence		Hospital		Physician	
New York		123 Main St		St. John's		Dr. Smith	

BUREAU V. S.

NOV 14 1955

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11348

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11323

Reg. Dist. No.

138

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bartholows				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Bartholows, Monrovia R.F.D.I			
3. NAME OF DECEASED (Type or print) John R Molesworth				4. DATE OF DEATH Month November Day 13 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9 1884	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frederick Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John A Molesworth		14. MOTHER'S MAIDEN NAME Anna M Clay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 214-36-0287		17. INFORMANT Thomas O Molesworth		Address Mt Airy R.F.D 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Minutes 5 years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B.O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) B.O. Thomas				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 13, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-15-56		22c. NAME OF CEMETERY OR CREMATORY PROVIDENCE CEMETERY		22d. LOCATION (City, town, or county) (State) KEMPTOWN MD	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Falcov				ADDRESS New Market Md		24a. REC'D BY REGISTRAR DATE 11-14-56	
				24b. REGISTRAR'S SIGNATURE Lucian K. Falcov			

NOV 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11320

CERTIFICATE OF DEATH

Reg. Dist. No.

11324

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fred. Memorial Hospital</u>				d. STREET ADDRESS <u>Le Gore</u>			
3. NAME OF DECEASED (Type or print) <u>EMMA</u> First <u>GRACE</u> Middle <u>NAUGLE</u> Last				4. DATE OF DEATH <u>Nov</u> Month <u>11</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 20, 1890</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Turner</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Schuller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mr. Napoleon Naugle, Le Gore, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE MYOCARDIAL FAILURE</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>COR PULMONALE</u> (c) <u>CHRONIC BRONCHIAL ASTHMA & PULMONARY EMPHYSEMA 20 YEARS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> <u>1 YEAR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1 Nov</u> , 19 <u>56</u> , to <u>11 Nov</u> , 19 <u>56</u> that I last saw the deceased alive on <u>11 Nov</u> , 19 <u>56</u> , and that death occurred at <u>945 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>11/13/56</u>							
ACTUAL SIGNATURE <u>James S. Stover, Jr.</u> M.D. JAMES E. STOVER, JR. WALKERSVILLE, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Le Gore md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>G. C. Barton Walkersville md</u>				24a. REC'D BY REGISTRAR DATE <u>15 Nov 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth B. Heach</u>	

BUREAU V. S.

NOV 16 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11325

11349

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Frederick</u>				c. LENGTH OF STAY IN 1b <u>5 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Frederick Co. Chronic Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MINNIE ELIZABETH NICHOLS</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>9</u> Year <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 18 75</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Ephraim Baker</u>				14. MOTHER'S MAIDEN NAME <u>Julia Winebrenner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs Ira Eyles, Thurmont RI, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>chronic myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis agitans</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>56</u> , to <u>Nov 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 8</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. F. Kline</u>				ADDRESS (Street, city or town, state) <u>Frederick Md.</u> DATE SIGNED <u>Nov 10 56</u>			
PHYSICIAN'S NAME (Type) <u>H. F. KLINE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/11/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton</u>				ADDRESS <u>Walkersville, md.</u>		24a. REC'D BY REGISTRAR DATE <u>14 Nov. 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

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NOV 16 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item -Block 22 Film 6207 11-20-56 et

11350

CERTIFICATE OF DEATH

11326

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cullen</u>			c. LENGTH OF STAY IN 1b <u>1249 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morningside, Md.</u>		<u>16 x - 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Victor Cullen State Hospital</u>				d. STREET ADDRESS <u>211 Maple Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Edward Nolan</u>			4. DATE OF DEATH Month Day Year <u>November 11 1956</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1887</u>		9. AGE (In years last birthday) <u>69</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ordinance Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Laboratory</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James E. Nolan</u>				14. MOTHER'S MAIDEN NAME <u>Mary Irwin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-05-3338</u>		17. INFORMANT <u>Wife - Mrs. Dorothy Nolan, Same as deceased patient's</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> <u>002x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19__		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>June 9</u> , 19 <u>53</u> , to <u>November 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>November 11</u> , 19 <u>56</u> , and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>I. B. Lyon</u> M.D. <u>Cullen, Maryland November 13, 1956</u> PHYSICIAN'S NAME (Type) <u>I. B. Lyon, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-14-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. L. Branger & Son</u>				ADDRESS <u>Thurmont Md</u>		24a. REC'D BY REGISTRAR DATE <u>11/13/56</u>	
24b. REGISTRAR'S SIGNATURE <u>I. B. Lyon</u>				24c. REGISTRAR'S SIGNATURE <u>I. B. Lyon</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 16 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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Item 9 Film G207 12-3-56 et

11322

121

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Emergency Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Carrie Mae Nuse		4. DATE OF DEATH Month II Day 13 Year 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dont Know Approx. 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Dermer		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT James Olden, Frederick, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 2 yrs. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 8, 1955, to Nov. 8, 1956, that I last saw the deceased alive on Nov 8, 1956, and that death occurred at 4 a.m., from the causes and on the date stated above.			
ACTUAL SIGNATURE H.F. Kline Sr.		M.D. Frederick Md.	
PHYSICIAN'S NAME (Type) H.F. Kline Sr.		DATE SIGNED Nov 14 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF II-15-56	
22c. NAME OF CEMETERY OR CREMATORY Reformed		22d. LOCATION (City, town, or county) (State) Knoxville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. L. Felt		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE NOV 19 1956		Bliz G. Hicks	

CERTIFICATE OF DEATH

Date of Death November 19, 1956		Place of Death Baltimore, Maryland	
Name of Deceased [Illegible]		Sex Male	
Age 45		Race White	
Date of Birth [Illegible]		Usual Residence [Illegible]	
Cause of Death [Illegible]		Manner of Death Natural	
Physician's Signature [Illegible]		Medical Examiner's Signature [Illegible]	
Hospital or Institution [Illegible]		Burial or Disposition [Illegible]	
Registrar's Signature [Illegible]		Date of Registration November 20, 1956	

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NOV 19 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11351

CERTIFICATE OF DEATH

11328

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent Home				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First NELLIE Middle V. Last OBERLANDER				4. DATE OF DEATH Month November Day 2 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1883		9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Neighbours				14. MOTHER'S MAIDEN NAME Villa B. Ramsburg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Chester W. Neighbours - Middletown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 7 days year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1953 , to November 2, 1956 , that I last saw the deceased alive on Oct. 28, 1956 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert S. Turner, Jr. M.D.				ADDRESS (Street, city or town, state) 7 E. Church St. Frederick, Md. DATE SIGNED 11-5-56			
PHYSICIAN'S NAME (Type) Dr. Robert S. Turner							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 5, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son ADDRESS Frederick - Ind.				24a. REC'D BY REGISTRAR DATE 5 Nov. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heub	

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11329

11322

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brunswick</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brunswick</i>			
c. LENGTH OF STAY IN 1b <i>Life</i>				d. STREET ADDRESS <i>16 East A. Street</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Allen</i> Middle <i>H.</i> Last <i>Phillips</i>				4. DATE OF DEATH Month <i>11</i> Day <i>27</i> Year <i>1956</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-2-1902</i>	
				9. AGE (In years last birthday) <i>54</i> yrs.		IF UNDER 1 YEAR Months <i>4</i> Days <i>24</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Prakeman-D.C.R.R.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
13. FATHER'S NAME <i>James A. Phillips</i>				14. MOTHER'S MAIDEN NAME <i>Ruby Simmons</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>705056164</i>		17. INFORMANT Address <i>Mrs. Gertrude Gertrude Phillips-Brunswick</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> 420.0 DUE TO <i>with heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Malnutrition, stroke</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>11/27</i> , 19 <i>56</i> , to <i>11/27</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>11/26</i> , 19 <i>56</i> , and that death occurred at <i>4:30</i> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Henry V. Chase</i> M.D.				ADDRESS (Street, city or town, state) <i>4 E. Church St. Frederick, Md.</i>			
DATE SIGNED <i>11/27/56</i>							
PHYSICIAN'S NAME (Type) <i>Henry V. Chase</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-30-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Park Heights</i>		22d. LOCATION (City, town, or county) (State) <i>Brunswick Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Eloa V. Feste</i> ADDRESS <i>Brunswick Md.</i>				24a. REC'D BY REGISTRAR <i>DEC 7 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Eugenia Barker</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 7 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11352 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11330

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown F.R.D I.		c. LENGTH OF STAY IN 1b 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown, F.R.D.I.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Linwood Samuel Price				4. DATE OF DEATH Month Day Year November II 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1915		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Employed farm hand)		10b. KIND OF BUSINESS OR INDUSTRY Frederick Co.		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrance Price				14. MOTHER'S MAIDEN NAME Georgia Turner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-30-4999		17. INFORMANT Address Mrs Linwood Price, Adamstown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 12 hr DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B.O. Thomas M.D.				DATE SIGNED November 12, 1956			
EXAMINER'S NAME (Type) B.O. Thomas				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Nov 15-56		22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hillman, Beallsville Md				24a. REC'D BY REGISTRAR DATE 11/13/56		24b. REGISTRAR'S SIGNATURE Charles W. Ely	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		TIME OF DEATH	
AGE		SEX	
RACE		RELIGION	
MARRIAGE		OCCUPATION	
EDUCATION		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		CLINICAL FINDINGS	
TREATMENT		PROGNOSIS	
FOLLOW-UP		REMARKS	

BUREAU V. S.

NOV 15 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11353 CERTIFICATE OF DEATH

Reg. Dist. No. 11331

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Walkersville</u>		c. LENGTH OF STAY IN 1b <u>75 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE WALTER REDDICK</u>		4. DATE OF DEATH Month Day Year <u>Nov. 2 19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Orra R. Reddick</u>		14. MOTHER'S MAIDEN NAME <u>Laura Valentine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Miss Rose Reddick, Walkersville, md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. Day, Year <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 Oct., 19 56</u> , to <u>2 Nov., 19 56</u> , that I last saw the deceased alive on <u>2 Nov., 19 56</u> , and that death occurred at <u>10 45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Walkersville, md.</u> DATE SIGNED <u>3 November 56</u>			
ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u>		M.D. <u>Walkersville, md.</u>	
PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/5/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>W. Libertytown md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Burton</u>		ADDRESS <u>Walkersville, md.</u>	
24a. REC'D BY REGISTRAR <u>5 Nov. 19 56</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heib</u>	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 139

11332

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen				c. LENGTH OF STAY IN 1b 47 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				d. STREET ADDRESS Olney, Md.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Earnest Middle Manning Last Reeve		4. DATE OF DEATH Month November Day 25 Year 19 56					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1874		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Knoxville, Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Felix Reeve			14. MOTHER'S MAIDEN NAME Wilhemina Manard				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. Spanish American		17. INFORMANT Deceased		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Myocardium & Pericardium DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Carcinoma of Lung DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 3 months Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from October 9, 19 56 , to November 25, 19 56 , that I last saw the deceased alive on November 25, 19 56 , and that death occurred at 5:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cullen, Maryland DATE SIGNED November 26, 19 56							
ACTUAL SIGNATURE <i>I. B. Lyon</i>			PHYSICIAN'S NAME (Type) I. B. Lyon, M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Cruger</i>			ADDRESS <i>Thurmont, Md.</i>		24a. REC'D BY REGISTRAR DATE 11/26/56	24b. REGISTRAR'S SIGNATURE <i>I. B. Lyon</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED Name: John A. Jones Sex: Male Date of Birth: May 15, 1874 Age: 35 Race: White Occupation: Teacher Usual Residence: 1234 Main St., Baltimore, Md. Date of Death: Nov. 10, 1956 Place of Death: Home Cause of Death: Heart Disease Immediate Cause: Myocardial Infarction Underlying Cause: Coronary Artery Disease Contributing Cause: None Manner of Death: Natural Physician: Dr. J. H. Smith Hospital: None Burial Place: Greenwood Cemetery, Baltimore, Md. Date of Burial: Nov. 12, 1956 Name of Undertaker: John Doe Signature of Physician: J. H. Smith Signature of Registrar: J. H. Smith Date of Registration: Nov. 10, 1956 Registrar's Office: Baltimore, Md.	
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RECEIVED
BUREAU V. 2
 NOV 27 1956

X

MEDICAL CERTIFICATION

VS AIS (4)
15M 9/SS

DEC 3 1956

RECEIVED

11323
CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <u>FREDRICK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>FREDRICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDRICK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDRICK #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDRICK MEMORIAL HOSP</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MARIE</u> Last <u>Saxon</u>		4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 13 1906</u>
9. AGE (In years last birthday) yrs. <u>50</u>		10. IF UNDER 1 YEAR: Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Carlton Preston Saxon</u>		14. MOTHER'S MAIDEN NAME <u>Anna Elizabeth Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>mother</u>	
17. INFORMANT <u>Frederick Rt #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>776X</u> DUE TO (c) <u>776X</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>13 Nov</u> , 19 <u>56</u> , to <u>14 Nov</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>14 Nov</u> , 19 <u>56</u> , and that death occurred at <u>4:24 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Guest</u>		ADDRESS (Street, city or town, state) <u>15 Nov 56</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>R. L. Guest</u>		<u>7 E. Church St. FREDERICK, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>17 Nov 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison and Son, Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>16 Nov 1956</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heub</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the funeral director. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11335

11324 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) UNIONVILLE		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) UNIONVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL				d. STREET ADDRESS FREDERICK MARYLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JEROME R. SNYDER			4. DATE OF DEATH Month Day Year NOVEMBER 1 19 56				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 31, 1894		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 2 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING.		11. BIRTHPLACE (State or foreign country) MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM E. SNYDER				14. MOTHER'S MAIDEN NAME MINERVA JANE RIPPEON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N		16. SOCIAL SECURITY NO. 219-36-2345		17. INFORMANT Address Mrs. GLADYS E. SNYDER, (WIFE)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 5 days 5 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Palmarary Coloma						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Angel , 19 52 , to Nov 1 , 19 56 , that I last saw the deceased alive on Nov 1 , 19 56 , and that death occurred at 6:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. L. Fahrney				ADDRESS (Street, city or town, state) DATE SIGNED 17 C Second St. Frederick Md 11-2-56			
PHYSICIAN'S NAME (Type) Dr. H. L. FAHRNEY, MD.				17, E. 2d. ST. FREDERICK, Md.			
22a. BURIAL CREMATION; REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV. 5, 1956		22c. NAME OF CEMETERY OR CREMATORY BRETHEN CHURCH CEMETERY		22d. LOCATION (City, town, or county) (State) MONROVIA, FRED. MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE DAILEY'S FUNERAL HOME FREDERICK, MARYLAND				24a. REC'D BY REGISTRAR 5 Nov. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11325

CERTIFICATE OF DEATH

11336

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 10 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS Mt. Pleasant	
3. NAME OF DECEASED (Type or print) First RUTH Middle ELIZABETH Last STINE		4. DATE OF DEATH Month November Day 25 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 31, 1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Heffner		14. MOTHER'S MAIDEN NAME Sallie Staley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Gladys Staley,		117 East Patrick Street, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) 5 yrs. INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 25 , 19 54 , to Nov 25 , 19 56 , that I lost saw the deceased alive on Nov. 25 , 19 56 , and that death occurred at 4:05 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Rex R. Martin M.D.		East Church Street, Frederick, Md. 11/27/56	
PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		Same as above	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 29, 1956	
22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS Frederick, Maryland	
24a. REC'D BY REGISTRAR DATE 28 Nov. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hebb	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	

RECEIVED
 NOV 29 1956
 BUREAU V. S.

NAME OF REGISTRAR [Illegible]	SIGNATURE OF REGISTRAR [Illegible]
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11356 CERTIFICATE OF DEATH

113371
Reg. Dist. No. 113371

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Woodboro</u>				c. LENGTH OF STAY IN 1b <u>6 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				d. STREET ADDRESS <u>Rural, Emmitsburg</u>			
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>STONESIFER</u> Last <u>STONESIFER</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 29 1882</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Hocken Smith</u>				14. MOTHER'S MAIDEN NAME <u>Julia Maxwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs. Dorsey Rippeau, Woodboro, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic nephritis</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Idiopathic collapse heart left failure</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>15 Aug.</u> , 19 <u>56</u> , to <u>16 Nov.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>15 Nov.</u> , 19 <u>56</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>WALKERSVILLE Md</u> DATE SIGNED <u>11/17/56</u>			
PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Keyville cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.C. Barton, Walkersville, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE 21 Nov. 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11357 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

11338

1. PLACE OF DEATH a. COUNTY <u>Fredesrick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont RFD 2</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fredesrick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pragerstown</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Effa</u> Last <u>Stull</u>				4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>1956</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 18, 1876</u>		9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Indesrick Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eli Freshman</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Harp</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Ralph Stull</u>		Address <u>Anytown Ind</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>B. O. Thomas</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Nov. 22-1956</u>			
EXAMINER'S NAME (Type) <u>B. O. Thomas</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 24-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lewisstown Cem</u>		22d. LOCATION (City, town, or county) <u>Lewisstown Fredesrick Co Md</u> (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Greger</u>				ADDRESS <u>Thurmont Md</u>		24a. REC'D BY REGISTRAR <u>DATE 24 Nov 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth V. Hark</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

NOV 27 1956

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11339

11358 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY ROUTE # 5. FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ROUTE # 5		c. LENGTH OF STAY IN 1b LIFETIME	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROUTE # 5. FREDERICK		d. STREET ADDRESS NONE	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH CALVIN STUP		4. DATE OF DEATH Month Day Year NOVEMBER 30 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 21, 1878
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Frederick County Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME EDWARD LEWIS STUP		14. MOTHER'S MAIDEN NAME VICTORIA WICKHAM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT PAUL STUP,		Address SHOOKSTOWN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma of face 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 yrs			INTERVAL BETWEEN ONSET AND DEATH 3 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/1/54 , 19 54 , to 11/30 , 19 56 , that I last saw the deceased alive on 11/25 , 19 56 , and that death occurred at 78 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED L. R. Schoolman M.D. 27 12/1/56			
ACTUAL SIGNATURE L. R. SCHOOLMAN MD.		22. NAME OF CEMETERY OR CREMATORY 228, N. Market. St. Frederick Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Dec. 3. 56.	22d. LOCATION (City, town, or county) (State) FREDERICK CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE DAVID S. GENERAL HOME		24a. REC'D BY REGISTRAR DATE 3 Dec. 1956	24b. REGISTRAR'S SIGNATURE Elizabeth G. Hech

BUREAU V. S.

DEC 7 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11340

Reg. Dist. No. 131

11326

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Pearl Frederick			c. LENGTH OF STAY IN 1b 2 who		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hosp.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Sr.			4. DATE OF DEATH Month November Day 18 Year 1956		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1918/1/19	9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months 3 Days 19 Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Henry Thomas		
14. MOTHER'S MAIDEN NAME Burque Younger			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. 217-16-3327			17. INFORMANT GRACE THOMAS - 163 W. ALL SAINTS		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from ruptured liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---					INTERVAL BETWEEN ONSET AND DEATH 13 days
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident			
20c. TIME OF INJURY Month 11 Day 5 Year 56 Hour 12 Min mid night 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40	
20f. (City or town) Nr. Pearl Frederick, Md.		20g. (County) ---			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED November 18, 1956	
EXAMINER'S NAME (Type) B.O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 21-56		22c. NAME OF CEMETERY OR CREMATORY Odd fellows	
22d. LOCATION (City, town, or county) Loudoun Co. Va.		(State) Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks		ADDRESS Fred. Md.		24a. REC'D BY REGISTRAR 21 Nov. 1956	
24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck					

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUN 23 1956
BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 11341										
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, R.F.D. 6					c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary Elizabeth Hillas Thomas					4. DATE OF DEATH Month November Day 5 Year 19 56					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1918- 3		9. AGE (In years last birthday) 38 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Va. Loudoun, Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Henry Hill					14. MOTHER'S MAIDEN NAME Virgie Ross					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-16-2411		17. INFORMANT Grace Thomas, 163 W. All Saint St. Frederick, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Babily fractured pelvis and ruptured Bladder DUE TO (c) Bladder										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 hours & 45 minutes										
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident						
20c. TIME OF INJURY Month, Day, Year 12 night II/5 19 56		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) (County) (State) nr. Pearl Frederick Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE B.O. Thomas					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) B.O. Thomas					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF Nov. 8-56		22c. NAME OF CEMETERY OR CREMATORY Odd Fellows		22d. LOCATION (City, town, or county) (State) London, Co. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III Frederick-Md.					24a. REC'D BY REGISTRAR DATE 7 Nov. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck			

MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Burial Officer	
13. Signature of Undertaker		14. Signature of Funeral Home		15. Signature of Cemetery	
16. Signature of Church		17. Signature of Minister		18. Signature of Rector	
19. Signature of Pastor		20. Signature of Priest		21. Signature of Rabbi	
22. Signature of Imam		23. Signature of Minister of Religion		24. Signature of Other Religious Officer	
25. Signature of Other Religious Officer		26. Signature of Other Religious Officer		27. Signature of Other Religious Officer	
28. Signature of Other Religious Officer		29. Signature of Other Religious Officer		30. Signature of Other Religious Officer	
31. Signature of Other Religious Officer		32. Signature of Other Religious Officer		33. Signature of Other Religious Officer	
34. Signature of Other Religious Officer		35. Signature of Other Religious Officer		36. Signature of Other Religious Officer	
37. Signature of Other Religious Officer		38. Signature of Other Religious Officer		39. Signature of Other Religious Officer	
40. Signature of Other Religious Officer		41. Signature of Other Religious Officer		42. Signature of Other Religious Officer	
43. Signature of Other Religious Officer		44. Signature of Other Religious Officer		45. Signature of Other Religious Officer	
46. Signature of Other Religious Officer		47. Signature of Other Religious Officer		48. Signature of Other Religious Officer	
49. Signature of Other Religious Officer		50. Signature of Other Religious Officer		51. Signature of Other Religious Officer	
52. Signature of Other Religious Officer		53. Signature of Other Religious Officer		54. Signature of Other Religious Officer	
55. Signature of Other Religious Officer		56. Signature of Other Religious Officer		57. Signature of Other Religious Officer	
58. Signature of Other Religious Officer		59. Signature of Other Religious Officer		60. Signature of Other Religious Officer	
61. Signature of Other Religious Officer		62. Signature of Other Religious Officer		63. Signature of Other Religious Officer	
64. Signature of Other Religious Officer		65. Signature of Other Religious Officer		66. Signature of Other Religious Officer	
67. Signature of Other Religious Officer		68. Signature of Other Religious Officer		69. Signature of Other Religious Officer	
70. Signature of Other Religious Officer		71. Signature of Other Religious Officer		72. Signature of Other Religious Officer	
73. Signature of Other Religious Officer		74. Signature of Other Religious Officer		75. Signature of Other Religious Officer	
76. Signature of Other Religious Officer		77. Signature of Other Religious Officer		78. Signature of Other Religious Officer	
79. Signature of Other Religious Officer		80. Signature of Other Religious Officer		81. Signature of Other Religious Officer	
82. Signature of Other Religious Officer		83. Signature of Other Religious Officer		84. Signature of Other Religious Officer	
85. Signature of Other Religious Officer		86. Signature of Other Religious Officer		87. Signature of Other Religious Officer	
88. Signature of Other Religious Officer		89. Signature of Other Religious Officer		90. Signature of Other Religious Officer	
91. Signature of Other Religious Officer		92. Signature of Other Religious Officer		93. Signature of Other Religious Officer	
94. Signature of Other Religious Officer		95. Signature of Other Religious Officer		96. Signature of Other Religious Officer	
97. Signature of Other Religious Officer		98. Signature of Other Religious Officer		99. Signature of Other Religious Officer	
100. Signature of Other Religious Officer		101. Signature of Other Religious Officer		102. Signature of Other Religious Officer	

BUREAU V. S.

NOV 9 1936

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11342
11359 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centerville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural Centerville-Fred. Co. Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last (Baby) Thompson				4. DATE OF DEATH Month Day Year November 19 19 56			
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 19, 1956		9. AGE (In years last birthday) yrs. Months Days Hours Mins 5	IF UNDER 1 YEAR Months Days Hours Mins	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Thomas Snowden				14. MOTHER'S MAIDEN NAME Ola Isabelle Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service *****		16. SOCIAL SECURITY NO. *****		17. INFORMANT Address Ola Isabelle Thompson Ijamsville R.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B.O. Thomas M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) B.O. Thomas				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-56		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Meth. Church		22d. LOCATION (City, town, or county) (State) Centerville Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III Frederick- Md.				24a. REC'D BY REGISTRAR DATE 19 Nov. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

1000222XVV

STATE OF MISSISSIPPI DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. OCCUPATION [REDACTED]</p>		<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. DATE OF BIRTH [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. COLOR [REDACTED]</p>		<p>9. RELIGION [REDACTED]</p>	
<p>10. PLACE OF DEATH [REDACTED]</p>		<p>11. DATE OF DEATH [REDACTED]</p>		<p>12. TIME OF DEATH [REDACTED]</p>	
<p>13. CAUSE OF DEATH [REDACTED]</p>		<p>14. MANNER OF DEATH [REDACTED]</p>		<p>15. SIGNATURE OF EXAMINER [REDACTED]</p>	
<p>16. SIGNATURE OF WITNESS [REDACTED]</p>		<p>17. SIGNATURE OF JURY [REDACTED]</p>		<p>18. SIGNATURE OF CORONER [REDACTED]</p>	

RECEIVED
NOV 1955
BUREAU V. S.

11329

CERTIFICATE OF DEATH

11343

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Frederick d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 618 Trail Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lulu Middle F. Last (Toms) Toms		4. DATE OF DEATH Month 11 Day 28 Year 1956	
5. SEX female	6. COLOR OR RACE W	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/1879
9. AGE (In years last birthday) yrs. 77		10. IF UNDER 1 YEAR Months 11 Days 28 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Isaac Brubaker		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. A. Earl Bussard, Frederick, Md.		18. ADDRESS 618 Trail Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Mesenteric Artery Thrombosis DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis of Aorta DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hrs Yes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Healed Ant. Myocardial Infarct			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-27 , 19 57 , to 11-28 , 19 57 , that I last saw the deceased alive on 11-28 , 19 57 , and that death occurred at 8:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 W 3rd ST DATE SIGNED 11-28			
ACTUAL SIGNATURE Thomas E. Stone M.D.		PHYSICIAN'S NAME (Type) Dr. Thomas E. Stone Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/56	
22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.		24a. REC'D BY REGISTRAR 30 Nov 1956	
24b. REGISTRAR'S SIGNATURE Elizabeth G. Hech			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11344

11329

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Three Pines Nursing Home				d. STREET ADDRESS 602 Trail Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALLEN Middle JOHN Last TROXELL			4. DATE OF DEATH Month November Day 21 , Year 1956				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 4, 1888		9. AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Electric Company		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles P. Troxell				14. MOTHER'S MAIDEN NAME Elizabeth Lehr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-3714		17. INFORMANT Mrs. Grace B. Troxell, 602 Trail Avenue, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7-8 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/17 , 19 56 , to 11/21 , 19 56 , that I last saw the deceased alive on 11/21 , 19 56 , and that death occurred at 2:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Professional Bldg., Frederick, Md. 11/21/56 ACTUAL SIGNATURE James B. Thomas M.D. PHYSICIAN'S NAME (Type) Dr. James B. Thomas Same as above							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF Nov. 23, 1956	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 23 Nov. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Burial Officer

Signature of Minister

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

BUREAU V. 2

NOV 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11345

11330

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 26 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home for the Aged		d. STREET ADDRESS 115 Record Street Home for the Aged	
3. NAME OF DECEASED (Type or print) First Rosa Middle Elizabeth Last Utz		4. DATE OF DEATH Month Nov. Day 30 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7-1871
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jasper T. Shriner		14. MOTHER'S MAIDEN NAME Susan Englar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Susie U. Siffrin (daughter)		Address 9 E. 2nd. St. Fred'k. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic congestive failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Ch. Auricular fibrillation DUE TO (c) Arterio-sclerotic heart dis.		INTERVAL BETWEEN ONSET AND DEATH 18 mos 2 yrs. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 54 to 30 Nov. 19 56 , that I last saw the deceased alive on 25 Nov. 19 56 , and that death occurred at 5:15 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Professional Bldg. DATE SIGNED 12/3/56	
ACTUAL SIGNATURE Charles H. Conley, Jr.		M.D. Frederick- Maryland	
PHYSICIAN'S NAME (Type) Dr. Charles H. Conley-Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-3-1956	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery		22d. LOCATION (City, town, or county) (State) Monrovia Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		ADDRESS Frederick- Maryland	
24a. REC'D BY REGISTRAR 3 Dec 1956		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		APRIL 14, 1928		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MAY 2, 1968		MEMPHIS, TENNESSEE		HEART DISEASE	
TIME OF DEATH		HOURS		MINUTES	
10:00 AM		10		00	
SEX		MARRIAGE		OCCUPATION	
MALE		MARRIED		ATTORNEY	
AGE		EDUCATION		RELIGION	
39		HIGH SCHOOL		METHODIST	
DATE OF BIRTH		PLACE OF BIRTH		CAUSE OF DEATH	
APRIL 14, 1928		MOBILE, ALABAMA		HEART DISEASE	
TIME OF BIRTH		HOURS		MINUTES	
10:00 AM		10		00	
SEX		MARRIAGE		OCCUPATION	
MALE		MARRIED		ATTORNEY	
AGE		EDUCATION		RELIGION	
39		HIGH SCHOOL		METHODIST	

RECEIVED
 DEC 4 1956
 BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11360

Item 3 Film G206 11-9-56 et

CERTIFICATE OF DEATH

11346

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Route 6-Nr. Pearl		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Annie Middle Wagoner Last Wagner		4. DATE OF DEATH Month November Day 4th Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1856
9. AGE (In years last birthday) 100 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Blackman		14. MOTHER'S MAIDEN NAME Elizabeth- ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Andrew Cole-Route 6-Frederick-Nr. Pearl		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis, general DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10-20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 20, 1956 , to Nov. 4, 1956 , that I last saw the deceased alive on Oct. 24, 1956 , and that death occurred at 11:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph L. Michels		ADDRESS (Street, city or town, state) New Market-Maryland	
PHYSICIAN'S NAME (Type) Dr. Ralph L. Michels		DATE SIGNED 11/5/1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-7-1956	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Pearl-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		24a. REC'D BY REGISTRAR 7 Nov. 1956	
ADDRESS Frederick-Maryland		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11334

CERTIFICATE OF DEATH

11347

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION I29 9th Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annalee Middle - Last Whipp		4. DATE OF DEATH Month II Day II Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1896
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR: Months 60 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin S. Forrest		14. MOTHER'S MAIDEN NAME Etta May Jennings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 260x	
17. INFORMANT Roman Whipp		Address Brunswick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Hepatitis & Diabetes		INTERVAL BETWEEN ONSET AND DEATH 6 1/2 hrs 3/19/56 trunk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/19 , 19 56 , to 11/11 , 19 56 , that I last saw the deceased alive on 11/11 , 19 56 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Md DATE SIGNED 11/12/56			
ACTUAL SIGNATURE J.G.F. Smith		M.D. Brunswick, Md	
PHYSICIAN'S NAME (Type) J.G.F. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF II-14-56	
22c. NAME OF CEMETERY OR CREMATORY Church of God		22d. LOCATION (City, town, or county) (State) Locust Valley, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. R. Lutz		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR NOV 19 1956		24b. REGISTRAR'S SIGNATURE Eugenia Burkey	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		RACE		EDUCATION		OCCUPATION		MARRIAGE		RELIGION		SOCIETY		POLITICAL PARTY		MILITARY SERVICE		NAVY SERVICE		ARMY SERVICE		AIR FORCE SERVICE		MARINE SERVICE		COAST GUARD SERVICE		OTHER SERVICE		REMARKS	
JAMES H. HARRIS		Male		65		1890		Baltimore, Md.		White		High School		Carpenter		Married		Roman Catholic		None		None		None		None		None		None		None		None		None			
Cause of Death		Immediate Cause		Intermediate Cause		Underlying Cause		Manner of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Anatomist		Signature of Surgeon		Signature of Dentist		Signature of Pharmacist		Signature of Nurse		Signature of Other Health Officer			
Heart Failure		Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Natural		Home		11-15-55		11:00 AM		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris			

BUREAU V. S.

NOV 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11331 CERTIFICATE OF DEATH

11348

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>				d. STREET ADDRESS <u>Thurmont, Maryland</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>OLIVER</u> First <u>XXXX</u> Middle <u>B.</u> Last <u>Wisotzkey</u>				4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-17-69</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Confectionary store</u>			
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>Frederick L. Wisotzkey</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Elizabeth Wisotzkey</u> Address <u>Thurmont MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>10-20</u> , 19 <u>56</u> , to <u>11-8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-8</u> , 19 <u>56</u> , and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>A.A. Pearre</u> M.D. <u>Frederick Md</u> PHYSICIAN'S NAME (Type) <u>A.A. Pearre</u> <u>Frederick Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov. 10-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cem.</u>	
22d. LOCATION (City, town, or county) <u>Thurmont, Fredk. Co.</u>				(State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Leager</u> ADDRESS <u>Thurmont MD</u>				24a. REC'D BY REGISTRAR <u>Elizabeth G. Hack</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Hack</u>	
DATE <u>10 Nov. 1956</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Memphis, Tennessee	
7. CAUSE OF DEATH FIRE		8. MANNER OF DEATH Suicide		9. PLACE OF BIRTH Mossburn, New South Wales, Australia	
10. OCCUPATION None		11. EDUCATION None		12. RELIGION None	
13. MARITAL STATUS Single		14. PREVIOUS MARRIAGES None		15. SIGNATURE OF DECEASED None	
16. SIGNATURE OF WITNESSES None		17. SIGNATURE OF PHYSICIAN None		18. SIGNATURE OF CORONER None	
19. SIGNATURE OF REGISTRAR None		20. SIGNATURE OF CLERK None		21. SIGNATURE OF JURY None	
22. SIGNATURE OF JUDGE None		23. SIGNATURE OF DISTRICT ATTORNEY None		24. SIGNATURE OF COUNTY CLERK None	
25. SIGNATURE OF STATE CLERK None		26. SIGNATURE OF U.S. DEPT. OF JUSTICE None		27. SIGNATURE OF FBI None	
28. SIGNATURE OF MEMPHIS POLICE None		29. SIGNATURE OF TENNESSEE STATE POLICE None		30. SIGNATURE OF MISSISSIPPI STATE POLICE None	
31. SIGNATURE OF ALABAMA STATE POLICE None		32. SIGNATURE OF LOUISIANA STATE POLICE None		33. SIGNATURE OF ARKANSAS STATE POLICE None	
34. SIGNATURE OF MISSOURI STATE POLICE None		35. SIGNATURE OF ILLINOIS STATE POLICE None		36. SIGNATURE OF INDIANA STATE POLICE None	
37. SIGNATURE OF OHIO STATE POLICE None		38. SIGNATURE OF MICHIGAN STATE POLICE None		39. SIGNATURE OF WISCONSIN STATE POLICE None	
40. SIGNATURE OF MINNESOTA STATE POLICE None		41. SIGNATURE OF IOWA STATE POLICE None		42. SIGNATURE OF NEBRASKA STATE POLICE None	
43. SIGNATURE OF KANSAS STATE POLICE None		44. SIGNATURE OF OKLAHOMA STATE POLICE None		45. SIGNATURE OF TEXAS STATE POLICE None	
46. SIGNATURE OF NEW MEXICO STATE POLICE None		47. SIGNATURE OF ARIZONA STATE POLICE None		48. SIGNATURE OF CALIFORNIA STATE POLICE None	
49. SIGNATURE OF NEVADA STATE POLICE None		50. SIGNATURE OF IDAHO STATE POLICE None		51. SIGNATURE OF MONTANA STATE POLICE None	
52. SIGNATURE OF WYOMING STATE POLICE None		53. SIGNATURE OF COLORADO STATE POLICE None		54. SIGNATURE OF UTAH STATE POLICE None	
55. SIGNATURE OF NEW MEXICO STATE POLICE None		56. SIGNATURE OF ARIZONA STATE POLICE None		57. SIGNATURE OF CALIFORNIA STATE POLICE None	
58. SIGNATURE OF NEVADA STATE POLICE None		59. SIGNATURE OF IDAHO STATE POLICE None		60. SIGNATURE OF MONTANA STATE POLICE None	
61. SIGNATURE OF WYOMING STATE POLICE None		62. SIGNATURE OF COLORADO STATE POLICE None		63. SIGNATURE OF UTAH STATE POLICE None	
64. SIGNATURE OF NEW MEXICO STATE POLICE None		65. SIGNATURE OF ARIZONA STATE POLICE None		66. SIGNATURE OF CALIFORNIA STATE POLICE None	
67. SIGNATURE OF NEVADA STATE POLICE None		68. SIGNATURE OF IDAHO STATE POLICE None		69. SIGNATURE OF MONTANA STATE POLICE None	
70. SIGNATURE OF WYOMING STATE POLICE None		71. SIGNATURE OF COLORADO STATE POLICE None		72. SIGNATURE OF UTAH STATE POLICE None	
73. SIGNATURE OF NEW MEXICO STATE POLICE None		74. SIGNATURE OF ARIZONA STATE POLICE None		75. SIGNATURE OF CALIFORNIA STATE POLICE None	
76. SIGNATURE OF NEVADA STATE POLICE None		77. SIGNATURE OF IDAHO STATE POLICE None		78. SIGNATURE OF MONTANA STATE POLICE None	
79. SIGNATURE OF WYOMING STATE POLICE None		80. SIGNATURE OF COLORADO STATE POLICE None		81. SIGNATURE OF UTAH STATE POLICE None	
82. SIGNATURE OF NEW MEXICO STATE POLICE None		83. SIGNATURE OF ARIZONA STATE POLICE None		84. SIGNATURE OF CALIFORNIA STATE POLICE None	
85. SIGNATURE OF NEVADA STATE POLICE None		86. SIGNATURE OF IDAHO STATE POLICE None		87. SIGNATURE OF MONTANA STATE POLICE None	
88. SIGNATURE OF WYOMING STATE POLICE None		89. SIGNATURE OF COLORADO STATE POLICE None		90. SIGNATURE OF UTAH STATE POLICE None	
91. SIGNATURE OF NEW MEXICO STATE POLICE None		92. SIGNATURE OF ARIZONA STATE POLICE None		93. SIGNATURE OF CALIFORNIA STATE POLICE None	
94. SIGNATURE OF NEVADA STATE POLICE None		95. SIGNATURE OF IDAHO STATE POLICE None		96. SIGNATURE OF MONTANA STATE POLICE None	
97. SIGNATURE OF WYOMING STATE POLICE None		98. SIGNATURE OF COLORADO STATE POLICE None		99. SIGNATURE OF UTAH STATE POLICE None	
100. SIGNATURE OF NEW MEXICO STATE POLICE None		101. SIGNATURE OF ARIZONA STATE POLICE None		102. SIGNATURE OF CALIFORNIA STATE POLICE None	

BUREAU V. S.

OV 14 1956

RECEIVED

APR 10 1968

U.S. DEPT. OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11332 CERTIFICATE OF DEATH

Reg. Dist. No.

11349

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS Route 6			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frank Middle Thomas Last Zepp				4. DATE OF DEATH Month November Day 14 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25-1907	
9. AGE (In years lost birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William T. Zepp				14. MOTHER'S MAIDEN NAME Daisy Oden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-24-3628		17. INFORMANT Mrs. Frank T. Zepp- Route 6-Frederick-Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 541.1 DUE TO Peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Subphrenic abscess DUE TO 5 days (c) Rupture of duodenal stump DUE TO 6 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 6 days			
21. I certify that I attended the deceased from 11/7 , 19 56 , to 11/14 , 19 56 , that I last saw the deceased alive on 11/14 , 19 56 , and that death occurred at 9:45 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Church St. DATE SIGNED 11-16-56 ACTUAL SIGNATURE Henry V Chase M.D. PHYSICIAN'S NAME (Type) Dr. Henry V. Chase Frederick-Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son ADDRESS Frederick-Maryland				24a. REC'D BY REGISTRAR DATE 17 Nov. 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

